

DEPARTMENT OF COMMERCE

STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

18

State File No. ....

Registrar's No. ....

Registration District No. ....

Primary Registration District No. ....

1. PLACE OF DEATH:

(a) County St. Louis  
(b) City or town St. Louis  
(c) Name of hospital or institution: Lutheran Hospital  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution  
In this community Five weeks (Specify whether years, months or days)

3. (a) PRINT FULL NAME June Olvera Austin

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Single  
6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if \_\_\_\_\_

7. Birth date of deceased March 21 1925  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
17 10 2 homicidal min.

9. Birthplace St. Louis, Missouri  
(City, town, or county) (State or foreign country)

10. Usual occupation Student

11. Industry or business \_\_\_\_\_

12. Name Wylie A. Austin

13. Birthplace St. Louis, Missouri  
(City, town, or county) (State or foreign country)

14. Maiden name Marion Edinfield

15. Birthplace Savannah, Georgia  
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. J. D. Kleykamp

(b) Address 5707 Westminster Pl.

17. (a) Burial (b) Date thereof January 26, 1943  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Funeral home

18. (a) Signature of funeral director Charles A. Bell

(b) Address 445 N. Washington Pl.

19. (a) JAN 25 1943 (b) J. D. Kleykamp  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Louis  
(c) City or town St. Louis  
(d) Street No. 5707 Westminster Pl.  
(If rural, give location)  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month December Day 22 Year 1942 Hour 7:45 Minute PM M.

21. I hereby certify that I attended the deceased from December 27 1942 to January 22 1943  
that I last saw her alive on January 22 1943  
and that death occurred on the date and hour stated above.

Immediate cause of death Tuberculosis - of Tubes  
Tubo-ovarian abscess

Due to Tuberculosis

Due to None

Other conditions (Include pregnancy within 3 months of death) None

Major findings: Tubo-ovarian abscess

Of operations \_\_\_\_\_

Of autopsy None

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) \_\_\_\_\_  
(b) Date of occurrence \_\_\_\_\_  
(c) Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)  
(d) Did injury occur in or about home, on farm, in industrial place, in public place? \_\_\_\_\_

While at work? \_\_\_\_\_ (Specify type of place) (c) Means of injury \_\_\_\_\_

23. Signature Heath H. Haines (M. D. or other) M.D.

Address 3617 Grandel Dr. Date signed 1/24/43

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

---

---

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....  
....., Registered Apprentice No.....  
working under my personal supervision.

Signed.....

*John Ketter*

Licensed Embalmer No.....

3882

P. O. Address.....

**Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)**

**If this body is not embalmed, fact should be so stated above.**